

**ATTACHMENT**

**C**

**PART 7**

LAKE COUNTY ADULT DETENTION FACILITY  
MEDICAL DIVISION  
104 E.Erie Street  
Painesville, Ohio 44077

CONSENT FOR RELEASE OF INFORMATION  
TO INCLUDE DRUG AND/OR ALCOHOL ABUSE

I hereby authorize FMC Rochester Minn (Mayo Clinic) to release  
information from the records of SKERS, KEVIN  
29480-1228 name 8-22-70  
S.S.N D.O.B.

The information to be released to The Lake County Adult Detention Facility/Dr. Baster for the purpose of treatment.

The information to be released is (itemized portions of record and time period)  
Discharge/Treatment Summery, Medication, Recommendations, Appropriate Lab and/or  
Xray Reports

IUP, urology report

I also understand that this consent is revocable upon written request to the extent that the action has been taken in reliance thereon, and the this consent will remain in force a reasonable time on order to effectuate the purpose for which it is given.(THIS AUTHORIZATION WILL BE IN EFFECT FOR 90 DAYS)

L : Kevin O. Sigg, Jr.  
Signature

\_\_\_\_\_  
Date

Abel  
Witness

\_\_\_\_\_  
Date

## HIV COUNSELING DOCUMENTATION

POST-TEST: Seronegative

1. Explain purpose of session.

2. Review confidentiality.

3. Test Information

a. Inform patient of negative test result.

b. Explain purpose of test.

c. Identify remaining risks.

d. Explain inability of test to detect early infections. (*false negatives*)

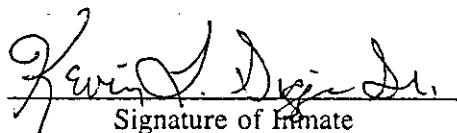
4. Explain risk reduction behaviors (*high risk*)

5. Discussed follow-up testing (*high risk*)

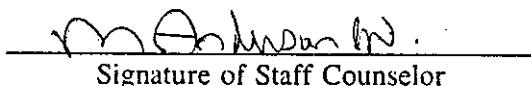
6. Give additional education material if requested.

7. Patient Reactions/Level of Understanding/Comments

I understand the above information.



Signature of Inmate



Signature of Staff Counselor

4/2/98  
Date

\*\*\*\*\*

## Seropositive Post-Test Counseling

1. Confidentiality review.

2. Patient informed of results of test by physician.

3. Patient referred to the psychology department for follow-up counseling.

51627-060

DOB 08-22-1970  
FMC ROCHESTER, MN  
Signature of Inmate

Signature of Staff Counselor

Date

U.S. DEPARTMENT OF JUSTICE  
Federal Bureau of Prisons

## HIV COUNSELING DOCUMENTATION

### Directions:

Use the following criteria to counsel the patient who is tested for the **HIV** antibody. Check off each item as they are discussed. Write NA beside any item that is inappropriate to the situation. Secure this form until pre- and post-test counseling is completed, then file this form in the patient's chart, documenting in the progress notes that counseling was completed as provided on forms BP-490 (61), BP-491 (61), and BP-492 (61) as appropriate.

### PRE-TEST:

1. Explain purpose of session.
2. Explain confidentiality.
3. Explain **HIV** antibody test.

SIGGERS

KEVIN L

B/M/O/08-22-1970

HT/601 WT/230

CUSTODY/IN

51627-060

HR/BK EY/BN

- a. What AIDS is
- b. What the test is
- c. Test Procedure
- d. Meaning of test results
- e. Inability to detect early infections (*false negatives*.)
- f. Possibility of false positives
- g. Possible need for additional testing
- h. Complications and consequence of a positive test.

4. List risk factors.
5. Explain prevention recommendations for persons with possible exposure.
6. Obtain informed consent (*when applicable*).
7. Risk Reduction Behaviors. Educational material provided.
8. Patient Reactions/Comments.

Inmate Name: \_\_\_\_\_

Register Number: \_\_\_\_\_

I understand the above information about the **HIV** test.

Signature of Inmate

Signature of Staff Counselor

Date

**MEDICAL DUTY STATUS CHECKLIST**  
**FEDERAL MEDICAL CENTER**  
**ROCHESTER, MINNESOTA**

<input type="checkbox"/> ALLRG/WOOL	<input type="checkbox"/> LIMIT SUN	<input type="checkbox"/> SOFT SHOES
<input type="checkbox"/> ART LIMB	<input type="checkbox"/> LOWER BUNK	<input type="checkbox"/> SPEC DIET
<input type="checkbox"/> ATH RESTR	<input type="checkbox"/> NO DRIVING	<input type="checkbox"/> STAND RSTR
<input type="checkbox"/> BED BOARD	<input type="checkbox"/> NO F/S	<input type="checkbox"/> SUIC WATCH
<input type="checkbox"/> COLD/WIND	<input type="checkbox"/> NO DUTY	<input type="checkbox"/> EFFECTIVE DATE
<input type="checkbox"/> DRIV RESTR	<input type="checkbox"/> NO POLLUT	<input type="checkbox"/> DELETE DATE
<input type="checkbox"/> HEAR RESTR	<input type="checkbox"/> NOT MED CL	<input type="checkbox"/> WGT 15 LB
<input type="checkbox"/> HGT RESTR	<input type="checkbox"/> ORTH SHOES	<input type="checkbox"/> WGT 20 LB
<input type="checkbox"/> HUNGR STRK	<input checked="" type="checkbox"/> REG DUTY <i>100% not med cl.</i>	<input type="checkbox"/> WGT 25 LB
<input type="checkbox"/> EFFECTIVE DATE	<input type="checkbox"/> REG DUTY W	<input type="checkbox"/> WIRED JAW
<input type="checkbox"/> DELETE DATE	<input type="checkbox"/> SMOKE FREE	

REGULAR DUTY WITH - NEEDS TO BE USED WHEN ANY OTHER DUTY STATUS IS ASSIGNED.

STAMP INMATE CARD HERE:

SIGGERS, KEVIN  
51b27-060

SIGGERS, KEVIN L

51b27-060

DOB 08-22-1970  
FMC ROCHESTER, MN

Louis S. Sterling, PA-C

Louis S. Sterling, PA-C  
FMC Rochester, MN

SIGNATURE STAMP

4/7/98

DATE

Done 4/7/98  
LH

**MEDICAL DUTY STATUS CHECKLIST**  
**FEDERAL MEDICAL CENTER**  
**ROCHESTER, MINNESOTA**

<input type="checkbox"/> ALLRG/WOOL <input type="checkbox"/> ART LIMB <input type="checkbox"/> ATH RESTR <input type="checkbox"/> BED BOARD <input type="checkbox"/> COLD/WIND <input type="checkbox"/> DRIV RESTR <input type="checkbox"/> HEAR RESTR <input type="checkbox"/> HGT RESTR <input type="checkbox"/> HUNGR STRK  <input type="checkbox"/> EFFECTIVE DATE  <input type="checkbox"/> DELETE DATE	<input type="checkbox"/> LIMIT SUN <input type="checkbox"/> LOWER BUNK <input type="checkbox"/> NO DRIVING <input type="checkbox"/> NO F/S <input type="checkbox"/> NO DUTY <input checked="" type="checkbox"/> NO POLLUT <input checked="" type="checkbox"/> NOT MED CL <input type="checkbox"/> ORTH SHOES <input type="checkbox"/> REG DUTY <input type="checkbox"/> REG DUTY W  <input type="checkbox"/> SMOKE FREE	<input type="checkbox"/> SOFT SHOES <input type="checkbox"/> SPEC DIET <input type="checkbox"/> STAND RSTR <input type="checkbox"/> SUIC WATCH  <input type="checkbox"/> EFFECTIVE DATE  <input type="checkbox"/> DELETE DATE <input type="checkbox"/> WGT 15 LB <input type="checkbox"/> WGT 20 LB <input type="checkbox"/> WGT 25 LB <input type="checkbox"/> WIRED JAW
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REGULAR DUTY WITH - NEEDS TO BE USED WHEN ANY OTHER DUTY STATUS IS ASSIGNED.

STAMP INMATE CARD HERE:

SIGGERS  
 KEVIN L 51627-060  
 B/M/O 08-22-1970  
 HT/601 WT/230 HR/BK EY/BN  
 CUSTODY/IN

*Gary J. Kunz* 3/26/98  
 SIGNATURE

Gary J. Kunz, FNP-C  
 FMC Rochester, MN

IGNATURE STAMP

*3/26/98*  
 ATE

*3/30/98*

## INMATE DISABILITY REPORTING FORM

INMATE NAME: \_\_\_\_\_ REG. NO.: \_\_\_\_\_ UNIT: \_\_\_\_\_

A disability refers to a permanent mental or physical impairment or condition that substantially limits one or more major life activities.

Please check the appropriate MDS and accommodation assignment(s):

 No disability identified at this timeSpeech impairment

<input type="checkbox"/> None needed	SPCH - NO AC
<input type="checkbox"/> Communication, P	SPCH - COM P
<input type="checkbox"/> Program, P	SPCH - PGM P
<input type="checkbox"/> Communication, U	SPCH - COM U
<input type="checkbox"/> Program, U	SPCH - PGM U
<input type="checkbox"/> Communication, N	SPCH - COM N
<input type="checkbox"/> Program, N	SPCH - PGM N

Vision impairment

<input type="checkbox"/> None needed	VISN - NO AC
<input type="checkbox"/> Communication, P	VISN - COM P
<input type="checkbox"/> Program, P	VISN - PGM P
<input type="checkbox"/> Communication, U	VISN - COM U
<input type="checkbox"/> Program, U	VISN - PGM U
<input type="checkbox"/> Communication, N	VISN - COM N
<input type="checkbox"/> Program, N	VISN - PGM N

Non-paralytic orthopedic impairment

<input type="checkbox"/> None needed	ORTH - NO AC
<input type="checkbox"/> Architectural, P	ORTH - ACC P
<input type="checkbox"/> Program, P	ORTH - PGM P
<input type="checkbox"/> Architectural, U	ORTH - ACC U
<input type="checkbox"/> Program, U	ORTH - PGM U
<input type="checkbox"/> Architectural, N	ORTH - ACC N
<input type="checkbox"/> Program, N	ORTH - PGM N

Complete paralysis

<input type="checkbox"/> None needed	TPAR - NO AC
<input type="checkbox"/> Architectural, P	TPAR - ACC P
<input type="checkbox"/> Program, P	TPAR - PGM P
<input type="checkbox"/> Architectural, U	TPAR - ACC U
<input type="checkbox"/> Program, U	TPAR - PGM U
<input type="checkbox"/> Architectural, N	TPAR - ACC N
<input type="checkbox"/> Program, N	TPAR - PGM N

Other physical impairment (permanent limitation of activity due to disease, including mobility, heart disease, car

<input type="checkbox"/> None needed	PHYS - NO AC
<input type="checkbox"/> Architectural, P	PHYS - ACC P
<input type="checkbox"/> Program, P	PHYS - PGM P
<input type="checkbox"/> Wheelchair, P	PHYS - WCH P
<input type="checkbox"/> Architectural, U	PHYS - ACC U
<input type="checkbox"/> Program, U	PHYS - PGM U
<input type="checkbox"/> Wheelchair, U	PHYS - WCH U
<input type="checkbox"/> Architectural, N	PHYS - ACC N
<input type="checkbox"/> Program, N	PHYS - PGM N
<input type="checkbox"/> Wheelchair, N	PHYS - WCH N

SIGGERS  
KEVIN L  
B/M/O/08-22-1970  
HT/601 WT/230 HR/BK EY/BN  
CUSTODY/IN

51627-060

Addressograph Here

Signature

Date

Gary J. Kunz, FNP-C  
FMC Rochester, MN

Signature Stamp

3/30/98  
3/30/98